TUFTS Health Plan

Rehabilitative Services: Occupational Therapy Authorization Form

Please fax the completed form to the plan listed below:

- Tufts Health Plan Commercial Plans; Fax: 617.972.9409
- Tufts Health Direct – Health Connector; Fax: 888.415.9055

1. Member name:	2. DOB:	3. DOI:	4. Date of report:
5. Member ID#:	6. Dx:	7. ICD-10:	
8. Facility Name:	9. Provider ID:	10. Facility phone #:	11. Facility fax:
12. Previous Rx for this Dx? Yes ☐ No ☐	13. Any other Dx? Yes ☐ No ☐	14. Total visits since start of care:	15. # of visits requested:
16. Start of care		17. Est D/C Date:	

18. Initial/Previous Clinical Status	19. Current Clinical Status	20. Current Functional Status
A. Pain Intensity: 0/10-10/10: _____	A. Pain Intensity: 0/10-10/10: _____	Use this scale for 1-4 (1: fully able 75-100%, 2: 50-75%, 3: 25-50%, 4: 0-25%)
B. ROM: _____	B. ROM: _____	A. Personal Care 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
C. Strength: _____	C. Strength: _____	B. Household Mobility 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
D. Alignment: _____	D. Alignment: _____	C. Community Mobility 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
E. Ambulatory Status/Balance: _____	E. Ambulatory Status/Balance: _____	D. Sitting Tolerance 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
F. Sensory/Reflexes: _____	F. Sensory/Reflexes: _____	E. Stair Climbing 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
		F. Driving 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
		G. Household Chores 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
		H. Lift Objects 1-10 lbs. 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
		I. Lift Objects >20 lbs. 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
		J. Work Tolerance 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐
		K. Sports/Recreation 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Comments: _____

21. Current Treatment Plan	22. Current Clinical Goals	23. Functional Outcomes

Provider name: _____ Provider #: _____

Requested by: _____ Signature: _____